



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ANDY NGUYEN
PO BOX 741865
DALLAS TX 75374

Respondent Name

Lumbermens Underwriting Alliance

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-14-0168-01

MFDR Date Received

September 18, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...TDI-DWC addresses Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations with Rule 134.204, Subsequent (k). ...This section also states testing shall be billed using the appropriate CPT codes & reimbursed in addition to the examination fee."

Amount in Dispute: \$111.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 20, 2013	Professional Services	\$111.84	\$109.55

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
- 28 Texas Administrative Code §134.204 sets out the guidelines for Workers' Compensation Specific Services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 97 – Charge included in another charge or service
 - R38 – Included in another billed procedure
 - 193 – Original payment decision maintained

Issues

1. Did the carrier support denial of disputed services?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as 97 – “Charge included in another charge or service.” Per 28 Texas Administrative Code §134.204(k) states, “The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be \$500 in accordance with subsection (j) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.” The carrier’s denial of disputed service 95851, “Range of motion measurements and report”, is not supported.
2. 28 Texas Administrative Code §134.203(c) is the applicable division fee schedule for calculation of the maximum allowable reimbursement for the services in dispute. For services in 2013, the maximum allowable reimbursement = (TDI-DWC Conversion Factor /Medicare CONV FACT) x Non-Facility Price or: (55.3 / 34.023) x 16.85 x 4 units = \$109.55
3. The total allowable for the disputed services is \$109.55. The carrier paid \$0.00. The requestor is seeking \$109.55. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$109.55.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$109.55 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March , 2014 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.